

FILED MAR 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4603

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u> Registrar's No. <u>214-C</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>9mo. 6day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>East St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Reilly VA Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>1207 Kansas</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>J.</u> c. (Last) <u>SPENCER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 4, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>December 17, 1919</u>		9. AGE (In years last birthday) <u>29</u>		10. IF UNDER 1 YEAR: Days <u>2</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Porter</u>		11. BIRTHPLACE (State or foreign country) <u>East St. Louis, Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>S.R.D. Spencer</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Roundtree</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW Two</u>		16. SOCIAL SECURITY NO. <u>350-18-9674</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>O'Reilly VA Hospital, Spfld., Mo.</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Pulmonary tuberculosis, far advanced, active.</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 29, 1948</u> , to <u>March 4, 1949</u> , that I last saw the deceased alive on <u>March 4, 1949</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE OF REGISTRAR <u>Paul L. Eisele</u> (Degree or title)		23b. ADDRESS <u>O'Reilly VA Hospital Spfld., Mo.</u>		23c. DATE SIGNED <u>3/5/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-6-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Barracks Natl</u>	
24d. LOCATION (City, town, or county) <u>St. Louis</u>		24e. (State) <u>Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Handley and Gorman-Schaefer</u> ADDRESS <u>Springfield, Mo</u>	
DATE REC'D BY LOCAL REG. <u>3/7/49</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Gorman-Schaefer</u> ADDRESS <u>Springfield, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4594

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.